Dep't of Health & Mental Hygiene v. Yee

OATH Index No. 520/19 (Apr. 5, 2019), *aff'd*, NYC Civ. Serv. Comm'n Index No. 2019-0436 (Sept. 5, 2019), **appended**

Evidence established that investigator inefficiently, negligently, or carelessly performed his duties on four occasions. Suspension without pay for 40 days recommended.

NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Petitioner
-against-
ROBERT YEE
Respondent

REPORT AND RECOMMENDATION

KEVIN F. CASEY, *Administrative Law Judge*

Petitioner brought this disciplinary proceeding under section 75 of the Civil Service Law, charging respondent, a medicolegal investigator in the Office of Chief Medical Examiner (OCME), with performing his duties in an inefficient, negligent, or careless manner on seven occasions and with being discourteous with a member of the public on one occasion (ALJ Ex. 1). Respondent denied committing misconduct.

At a three-day trial, which ended on February 15, 2019, petitioner relied on documentary evidence and testimony from Nicholas Schultz, deputy director of OCME's forensic investigations unit; Daniel Cooney, former deputy director of that unit; and three deputy medical examiners, Dr. Michael Greenberg, Dr. Melissa Pasquale-Styles, and Dr. Michele Slone. Respondent testified in his own behalf, offered documentary evidence, and presented testimony from two of his direct supervisors, tour commanders Donna LaBella and Carla DeVito.

For the reasons below, the charges should be sustained in part and respondent suspended without pay for 40 days.

ANALYSIS

OCME is responsible for investigating unexpected or unusual deaths (Schultz: Tr. 14). For more than 23 years, respondent, who is also a physician's assistant, has worked for OCME as a medicolegal investigator (Tr. 20). His main duties are to investigate, determine whether OCME should assert jurisdiction, and prepare a detailed written report for each assigned case (Tr. 20-21).

When a death occurs in a health care facility, an investigator phones the facility and gathers information about the decedent's arrival at the facility and the course of treatment (Schultz: Tr. 20, 59; Cooney: Tr. 221). For a death due to natural causes, a physician may sign the death certificate and OCME will not assert jurisdiction (Schultz: Tr. 20). However, if it was an unnatural or unexpected death, investigators will gather more information (Tr. 20). If the death occurs in a home or public place, rather than a health care facility, it is referred to as a "scene" case, and the investigator goes to the scene, obtains information from the police, interviews witnesses and family members, and review other records, such as emergency medical service (EMS) reports (Schultz: Tr. 21-22, 30, 58). Investigators submit their written reports at the end of each shift (Cooney: Tr. 225). As Mr. Cooney explained, medical records are not always available (Tr. 226). And, in most cases, ambulance care reports prepared by EMS workers are not available to OCME investigators by the time they are expected to submit their reports (Tr. 225).

There are approximately 22 investigators and five supervisors, referred to as tour commanders, who assign work (Schultz: Tr. 56). Last year, the forensic investigations unit handled 16,000 scene cases and 8,000 hospital cases (Tr. 57). The main document prepared by investigators, referred to as the investigation report, has four parts: basic facts, including the decedent's name and age; a case synopsis, with cause of death; the investigator's subjective statement regarding observations at the scene; and additional information from family contacts or elsewhere (Tr. 196). According to Mr. Cooney, he tries to keep his own reports as detailed as possible, but he also tries to keep them concise, usually about one or two pages long (Tr. 197).

At a triage meeting every morning, medical examiners review the investigators' written reports for the previous 24 hours and decide which cases OCME will accept jurisdiction over (Schutz: Tr. 30). Medical examiners can overrule an investigator's decision to accept or reject jurisdiction over a case, and they do so as often as once per month (Tr. 70). Because medical

examiners make findings regarding the cause and manner of death and have authority to approve organ transplants or to perform an autopsy over a family's religious objections, they rely on investigators to provide comprehensive reports (Tr. 31). If necessary information is initially unavailable, the medical examiners will request follow-up reports, but they try to avoid repeated calls to grieving family members for additional information (Tr. 34).

The petition alleges that respondent committed misconduct by negligently failing to take jurisdiction over a case in November 2017 and failing to perform adequate investigations of six other cases from November 2017 to July 2018. Petitioner also accused respondent of being discourteous during a phone conversation with a decedent's daughter in February 2018.

Denying that he committed misconduct, respondent stressed that petitioner has taken issue with a small fraction of the hundreds of reports that he prepared each year, he regularly received very good performance evaluations, he was not aware of recent complaints about his reports, and he was receptive to suggestions for improvement (Tr. 10-12). He denied that he had been discourteous to a decedent's family member. Supervisors confirmed that investigators are working under increased pressure, in part because of decreased staffing and the opioid epidemic (Cooney: Tr. 219-20; DeVito: Tr. 351-52). In general, respondent's immediate supervisors were unaware of significant problems with his work (LaBella: Tr. 341; DeVito: Tr. 347-48).

Petitioner has the burden of proving the charges by a preponderance of the evidence. *See Dep't of Correction v. Hall*, OATH Index No. 400/08 at 2 (Oct. 18, 2007), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 08-33-SA (May 30, 2008). Where resolution of the charges hinges on witness credibility, relevant factors include: demeanor; consistency; supporting or corroborating evidence; and the degree to which testimony comports with common sense. *See Dep't of Correction v. Hansley*, OATH Index No. 575/88 at 19 (Aug. 29, 1989), *aff'd sub nom. Hansley v. Koehler*, 169 A.D.2d 545 (1st Dep't 1991). Here, for the most part, I found all of the witnesses for both sides to be credible. Though there were differences in their opinions about respondent's performance, each witness made a good faith effort to recall events accurately. Every one of them impressed me as an experienced professional, dedicated to the agency's mission.

Charge I - Inefficient, negligent, or careless performance of duties

Petitioner alleged that respondent inefficiently, negligently, or carelessly performed his duties on seven occasions from November 2017 to July 2018. As this tribunal has long

recognized, not every error is misconduct; all employees make mistakes. *See Financial Information Services Agency v. Boritz*, OATH Index No. 744/91 at 14, 16 (Apr. 16, 1991), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 91-147 (Dec. 10, 1991) (among factors to be considered in determining whether mistakes amount to misconduct are the frequency of errors committed by similarly situated employees and the consequences to the agency, including amount of time that supervisors need to spend monitoring employee). To prove misconduct there must be some showing of repetitive or fundamental errors that demonstrate negligence or carelessness. *See Human Resources Admin. v. Hines*, OATH Index No. 073/17 at 9-10 (Mar. 17. 2017), *aff'd*, NYC Civ. Serv. Comm'n Case No. 2017-0431 (Sept. 25, 2017) (eligibility specialist's failure to process seven claims for 22 or more days, or notify supervisor that there was a problem, deemed negligence, where applicants faced loss of benefits due to employee's inattentiveness); *Dep't of Consumer Affairs v. Laguda*, OATH Index No. 658/10 at 9-10 (Feb. 10, 2010) (negligence shown where employee failed to make required entries on three occasions, despite repeated reminders, and refused assistance or counseling). Occasional or minor errors, with minimal impact on agency operations, do not constitute misconduct. *See Dep't of Environmental Protection v. Saint Louis*, OATH Index No. 195/16 at 19 (Dec. 21, 2015), *adopted*, Comm'r Dec. (Mar. 4, 2016) (isolated errors in audits by research scientist not deemed misconduct); *see also Fire Dep't v. Hodge*, OATH Index No. 574/06 at 6-8 (May 18, 2006) (isolated errors on emergency medical technician's ambulance reports were not misconduct, because the reports were complex, requiring "discretionary decisions on how best to record the data while meeting the exigencies demanded in the field by the nature of the call and the needs of the patient," and there was no proof that employee's reports deviated from other employees' reports, that errors impacted patient care, or that employee had been warned that the errors could result in charges).

Here, experienced staff testified about deficiencies in respondent's reports. The evidence also showed that respondent had a great deal of discretion in how to complete the reports and he received minimal guidance regarding purported deficiencies. In four instances, petitioner showed that the errors were so serious that they amounted to misconduct. Thus, the charge should be sustained in part. The specific allegations are as follows:

Case B-17-2442 (Specification B) - sustained

Petitioner alleged that, on November 3, 2017, respondent performed an inadequate

investigation of the death of a 26-year-old man with a history of autism and mental retardation, whose family saw him become suddenly unresponsive in their shared apartment (Greenberg: Tr. 96; Pet. Ex. 3). According to petitioner, respondent's report did not include necessary information from the decedent's mother about the decedent's history of autism and mental retardation, the cause of the mental retardation, the severity of his autism, his baseline condition, and the activities leading up to his fatal collapse. Petitioner asserted that this information was essential because the next of kin had a religious objection to an autopsy and a medical examiner needed to certify the cause of death (ALJ Ex. 1).

In his one-page report, respondent classified this as an OCME case and noted that EMS found the decedent non-verbal and in cardiac arrest before taking him from his home to a hospital, where he died in the emergency room (Greenberg: Tr. 96; Pet. Ex. 3). Respondent noted that the ambulance call report was unavailable but, according to EMS personnel, there was no reported history of alcohol or drug abuse and no reports of a recent fall or fighting (Tr. 96; Pet. Ex. 3). Other than a superficial abrasion on the decedent's knuckles, there were no other deformities and there were no hospital test results (Tr. 97; Pet. Ex. 3). Because it was classified as an OCME case and the family, who were Muslim, objected to an autopsy on religious grounds, respondent informed the family that they needed to positively identify the body in person or by viewing a photograph at OCME's office (Tr. 97; Pet. Ex. 3).

On November 3, Dr. Greenberg received an e-mail from the medical examiner assigned to this case (Tr. 98; Pet. Ex. 14). The medical examiner noted that respondent's report left many questions unanswered (Pet. Ex. 14). Respondent did not report the decedent's baseline condition before his collapse, did not state whether the decedent was ambulatory or bed-ridden, did not state what he was last seen doing before he was found unresponsive, and did not note the degree of autism (Tr. 97; Pet. Exs. 3, 14). According to the medical examiner, "we need to rule out remote trauma" as the cause of the reported mental retardation (Pet. Ex. 14). The level of autism was relevant because he may have been dependent on others for care (Tr. 101). In a reply e-mail, Dr. Greenberg asked whether the Administration for Children's Services had a history with the decedent's family; however, it was undisputed that a forensic pathology coordinator, rather than an investigator, normally obtained such information (Pet. Ex. 14; Tr. 110-11).

Later that day, Dr. Greenberg sent an e-mail to Mr. Cooney, then deputy director of investigations, and described respondent's report as "very worrisome" (Pet. Ex. 14). Mr. Cooney

forwarded the e-mails to respondent and wrote, "It appears you dropped the ball on this one. From reading the report, you did not ask the mother about the decedent's history. The report is lacking essential content that you could have tracked down. I know that you are capable of better work" (Pet. Ex. 14).

At trial, Dr. Greenberg explained that the case required a thorough investigation because OCME needed to decide whether to release the body or to perform an autopsy over the family's religious objections (Tr. 100). Dr. Greenberg emphasized that respondent noted in his report that he had spoken with the decedent's mother on the phone (Tr. 113; Pet. Ex. 3). According to Dr. Greenberg, during that phone conversation with the decedent's mother, any competent investigator would have asked about the decedent's medical history (Tr. 113).

If respondent could not get information from a grieving family member, he should have added one sentence to his report that "an attempt was made to elicit further medical history" and explained why he could not obtain that information (Tr. 114). Because respondent failed to explain the absence of such information, which witnesses referred to as a "pertinent negative," readers of his report would not know whether he asked relevant questions (Greenberg: Tr. 114; Slone: Tr. 162-63). If a report omits reference to a relevant issue, medical examiners assumed that the investigator never asked about it.

Respondent testified that he classified this matter as an OCME case because there was a lack of available information (Tr. 258). The reporting physician did not have much information because EMS brought him to the hospital and the ambulance report, which normally includes the circumstances of the discovery of the decedent, was unavailable (Tr. 258-59). Respondent acknowledged that, after receiving the e-mails from Mr. Cooney about this case, he tried to include more details in his later reports regarding his discussions with decedents' families (Tr. 261).

This specification should be sustained. Petitioner proved that respondent's terse one-page report was so inadequate that it showed negligence. Dr. Greenberg persuasively testified that no other investigator would have submitted such an inadequate report without more details about an autistic or mentally retarded decedent's medical history. Petitioner also showed that respondent's errors caused tangible harm. Dr. Greenberg noted that people of the Muslim faith prefer to bury their loved ones as quickly as possible and respondent's inadequate report led to a delay of at least one day (Tr. 102-03). As an experienced investigator, respondent knew or

should have known that he needed to note the lack of available information in his report. *See Dep't of Environmental Protection v. Espana*, OATH Index No. 1680/07 at 2 (Aug. 30, 2007) (neglect of duty shown where experienced watershed maintainer turned off a valve in violation of agency policy).

Case M-17-025358 (Specification D) – sustained

Petitioner alleged that respondent failed to perform an adequate investigation of a case on November 13, 2017, involving the death of 19-year-old woman with no prior medical history (ALJ Ex. 1; Pet. Ex. 7). In his report, respondent classified the matter as an OCME case and noted that, according to the ambulance report, "the decedent was witnessed to suddenly collapse and was found in cardiac arrest by responding EMS" (Pet. Ex. 7). Petitioner claimed that respondent's report did not include necessary basic information, such as the circumstances of the decedent's collapse, the identity of witnesses, or information regarding the location where the collapse occurred (ALJ Ex. 1).

In an e-mail to the unit director, Mr. Cooney, on November 13, Dr. Slone stated that respondent's report was "unacceptable and almost useless" (Pet. Ex. 18). Another investigator, Ms. DeVito, provided a supplemental report (Pet. Ex. 18). Dr. Slone noted that Ms. DeVito obtained blood test results that respondent did not order and spoke with the decedent's mother, who provided all of the information needed to authorize organ donation (Pet. Ex. 18).

At trial, Dr. Slone noted that respondent spoke to the decedent's mother (Tr. 175; Pet. Ex. 7). Thus, Dr. Slone assumed, respondent should have been able to elicit more information (Tr. 175). For example, he could have asked the decedent's mother whether the incident occurred at home, whether the decedent had been with friends, whether there was an altercation, and whether the decedent had been using drugs (Tr. 175).

Respondent testified that it was clearly an OCME case because it involved the unexpected death of a young person with no significant medical history (Tr. 279-80). Though respondent agreed that more information would have been helpful, he insisted that it was unavailable (Tr. 279-80). The decedent's mother, who did not witness her daughter's collapse, was very emotional, gave very brief answers, and said that she would prefer to speak with an investigator at some other time because she was at her dying daughter's bedside (Tr. 280-82).

Ms. DeVito, an investigator and tour commander who has worked for OCME for 18

years, confirmed that Dr. Slone was upset that respondent's report lacked information needed before organ donation could be approved (Tr. 347-48). Because respondent was off duty, Ms. DeVito called the decedent's family for more details (Tr. 349). According to Ms. DeVito, it was a "common occurrence" that information was unavailable and others had to follow up (Tr. 349).

According to Ms. DeVito, she later discussed this report with respondent and the need to document pertinent negative information or the inability to obtain details (Tr. 349). She recalled that he "absolutely agreed" that the report lack sufficient information (Tr. 349).

Petitioner did not prove that respondent's deficient report unduly delayed an organ transplant. The evidence showed that family members are not always aware of relevant information or sometimes they are too distraught to answer questions. Thus, it is occasionally necessary for a second investigator to conduct further investigation and provide a supplemental report. Though Dr. Slone speculated that the decedent's mother should have been able to provide more information when respondent first contacted her and another investigator eventually obtained necessary information, petitioner did not introduce the supplemental report into evidence. There was no evidence that the decedent's mother was willing or able to answer all of respondent's questions when he first called her.

However, even if the decedent's mother was unable to provide useful information when respondent first spoke to her, petitioner proved that his report was negligently prepared. It was undisputed that petitioner expects investigators to note whether they asked relevant questions and to report what, if any, response they receive to those questions. Respondent's report failed to include those basic details. This was especially troubling here, because ten days earlier, respondent's supervisor alerted him to a similar mistake via e-mail. Despite receiving that feedback, respondent repeated the same fundamental mistake. That was negligent.

Case B-17-25783 (Specification C) – not proved

Petitioner alleged that respondent negligently investigated the death of a 66-year-old man. In a report on November 18, 2017, respondent noted that the decedent had been diagnosed with metastatic liver cancer in 2015 and had hepatitis C, prior vascular surgery on his left leg, a history of intravenous drug and cigarette use, and no reported current drug or cigarette use (Pet. Ex. 6). Respondent wrote that the decedent shared an apartment with his sister, the decedent's niece found the decedent in a chair at his home that morning, the police did not find anything

suspicious, and the decedent's sister had no religious objection to an autopsy (Pet. Ex. 6).

According to petitioner, the report omitted necessary details about the decedent's history of intravenous drug use, his current drug use, and the extent of the decedent's cancer. Petitioner further claimed that, although there were no religious objections to an autopsy, respondent's report "failed to mention that a Quran and crucifix were present at the scene" and, despite the report's reference to previous surgery on the decedent's leg, respondent did not note that the leg was wrapped in gauze and an ace bandage from the knee to the foot (ALJ Ex. 1).

In his report, respondent classified this matter as "certified at the scene" rather than an OCME case (Pet. Ex. 6). According to Dr. Slone, that meant if there was a doctor at the scene who could sign a death certificate stating that it was a natural death, OCME would release the decedent's body to the family for burial (Tr. 147, 168). If no doctor was available at the scene, the decedent's body would be brought to OCME's offices where a medical examiner would be responsible for signing the death certificate (Tr. 147). In this situation, unlike an "OCME case," a medical examiner could sign the death certificate without viewing the body or performing an autopsy when an investigator provides a detailed report and there was reliable information that the death was from natural causes (Tr. 147-48, 164).

Here, however, the assigned medical examiner, was "very concerned" about signing the death certificate (Tr. 148). According to Dr. Slone, the patient's 2015 cancer diagnosis required follow-up questions regarding the course of treatment and the extent of the metastases (Tr. 170). As Dr. Slone explained, "metastatic" meant that the cancer had spread beyond the liver, but it did not mean that it had spread throughout the entire body (Tr. 170). Nor did it mean that the cancer had anything to do with the cause of death (Tr. 170-71). Similarly, the decedent may have contracted hepatitis C from intravenous drug use, but more questions needed to be asked about the decedent's recent drug use (Tr. 149).

Dr. Slone testified that a medical examiner further investigated this case by making multiple phone calls to the next of kin (Tr. 151). According to the medical examiner's supplemental report, the decedent's sister stated that the decedent had been in a methadone program until the day he died and was on a "very high" dosage, due to the tolerance that he had developed. The decedent's pain management doctor had also prescribed Percocet, but wanted him to cut back. With regard to his cancer, the decedent had developed a leg infection following chemotherapy and his doctors wanted to amputate his leg. The decedent stopped going to his

doctor and refused further medical treatment. His sister told the medical examiner that the decedent had become very secretive, he went outside for long periods, and she suspected that he had resumed illegal drug use (Pet. Ex. 6; Tr. 170-71).

The medical examiner also performed a limited examination of the decedent's body at OCME's offices, by unwrapping the gauze on the decedent's left leg, which revealed that the leg was discolored and had a large ulcer (Pet. Ex. 6; Tr. 151). Based on the supplemental report, the case was reclassified as an OCME case and an autopsy was later performed (Pet. Ex. 6; Tr. 150).

Respondent testified that he went to the decedent's home, did not observe any signs of trauma or untoward activity (Tr. 274). There was no evidence of any current drug use (Tr. 275). Respondent spoke to the decedent's sister, who was "quite distraught," and determined that the family had no religious objections to an autopsy (Tr. 274-75). Though the decedent's sister said that the liver cancer had spread, she did not know its full extent (Tr. 275). There was no mention of methadone use (Tr. 275). According to respondent, he noted that there was a bandage on the decedent's leg, but it was not soiled or bloody and there was no report of any recent surgery (Tr. 316-17). Respondent photographed the scene, which included numerous religious objects, and later uploaded those photographs in OCME's database (Tr. 275).

Though Dr. Slone sent an e-mail to respondent's supervisor, Mr. Cooney, and four others regarding this investigation, the e-mail was not sent to respondent and nobody ever spoke to him about it at that time (Pet. Ex. 17; Tr. 177, 278). At trial, after hearing Dr. Slone's testimony, respondent acknowledged that his report could have included more documentation, including pertinent negative information (Tr. 317).

As respondent conceded, his report could have been more thorough. But petitioner failed to prove that respondent negligently prepared the report. For example, petitioner faulted respondent for not including necessary information about the decedent's current drug use. Yet respondent's report noted that he interviewed the police who found no evidence of untoward circumstances, he personally viewed the scene and saw no illegal drugs or drug paraphernalia, he spoke to the next of kin, and there was "no reported" current drug use (Pet. Ex. 6). Although a medical examiner was later able to obtain more information about the decedent's drug use, that does not prove that the decedent's family would have been more forthcoming when they spoke to respondent at the scene. Indeed, the evidence showed supplemental reports were often required and, in this case, it took multiple calls with the next of kin to gather more information.

Similarly, petitioner argued that it was negligent to omit from the report that there was Quran at the scene. Petitioner's position appears to be that, even though the family had no objection to an autopsy, respondent should have inferred from the presence of a Quran that the decedent would have objected to an autopsy or, at the very least, respondent should have noted the presence of the Quran in his report. However, there was no credible evidence that other investigators routinely noted the presence of a Quran in their reports, especially when the next of kin have no religious objections to an autopsy. Though the petition alleged that there was a Quran and a crucifix at the scene, petitioner did not introduce the photographs that respondent took of the scene or offer any evidence where the various religious objects were located (ALJ Ex. 1).

Petitioner did not prove that the presence of the Quran somewhere in the decedent's home was an essential fact that respondent was required to include in his report. As petitioner's witnesses acknowledged, investigators must submit their reports by the end of each shift, in time for the review by medical examiners at the beginning of each day. Petitioner does not give investigators a checklist of items that must be included in every report. Instead, petitioner gives investigators broad discretion to report their findings after conducting probing and tactful inquiries. As with many judgment calls, reasonably competent professionals may disagree about what constitutes an important detail. That is what happened here. *See Hodge*, OATH 574/06 at 6.

As for the decedent's left leg injury, the parties offered conflicting evidence. Petitioner presented a hearsay statement from a medical examiner who reported that the decedent's sister told him that the decedent had a leg infection and the doctors wanted to amputate his leg. The medical examiner then performed a limited, preliminary observation of the decedent at OCME's office. After removing gauze and an ace bandage below the left knee, the medical examiner found the decedent's leg had a large ulcer and discoloration (Pet. Exs. 6, 17). Respondent testified that the bandage appeared clean and there was no report of recent surgery (Tr. 316-17). Ideally, respondent would have discovered the leg injury and included it in his report. However, petitioner did not offer any evidence that OCME policy required investigators to remove all bandages or that, based on what respondent knew, most investigators would have removed the bandage from the decedent's leg.

Case Q-17-026784 (Specification A) – sustained

This appeared to be the most serious charge against respondent. Petitioner alleged that respondent negligently, inefficiently, or carelessly failed to take jurisdiction over an OCME case, where the decedent was a 12-year-old child, with a dislodged tracheostomy tube. EMS brought the child from his school to a hospital, where he died on November 27, 2017 (ALJ Ex. 1; Pet. Ex. 2). According to petitioner, respondent should have classified the matter as an OCME case and investigated how the tube became dislodged (ALJ Ex. 1).

In his report, respondent classified this matter as "no case," meaning OCME would not take jurisdiction (Pet. Ex. 2; Tr. 87). Respondent noted that decedent had a tracheostomy tube and was at school when the tube dislodged, school staff could not put the tube back in place, but EMS personnel were able to insert a breathing tube (Pet. Ex. 2). However, the ambulance report was unavailable (Pet. Ex. 2). Respondent further noted that the decedent had a past medical history, including mental retardation, cerebral palsy, a seizure disorder, bacterial meningitis (an infection around the brain membrane that occurred during infancy), past surgical history, past ventilator dependency, and placement of a gastric tube (Pet. Ex. 2; Tr. 89).

Respondent's report also included details from the reporting physician, who stated that the decedent had no bruising, wounds, or obvious deformities, and did not respond to stimuli in the emergency room (Pet. Ex. 2; Tr. 89-90). There was no discoloration of the skin associated with lack of oxygen; the decedent's white blood cell count was elevated; liver function tests were also elevated; there was no airway obstruction; a chest x-ray showed some findings in the lungs, which is subject to interpretation by a radiologist; and a specialist reinserted the tracheostomy tube at the hospital (Tr. 90). The decedent was placed on a ventilator; there was an MRI of the head, which showed "diffuse strokes," that required clarification; next of kin withdrew care and the decedent was on a ventilator awaiting evaluation by an organ donor transplant team (Tr. 91; Pet. Ex. 2).

Dr. Greenberg testified that the assigned medical examiner was uncomfortable releasing the decedent's body without asserting OCME jurisdiction over the case (Tr. 87). Though Dr. Greenberg described respondent's report as "helpful," he disagreed with respondent's finding that it was not an OCME case (Tr. 87-88). According to Dr. Greenberg, medical devices do not normally dislodge without some degree of force and the dislodging of a medical device was, by definition, the type of accident that OCME investigates (Tr. 88, 94-95, 104). Moreover, because

the accident took place in a school, respondent should have asked many more questions and included the responses in his report (Tr. 88, 94). For example, respondent should have noted the decedent's mobility and baseline condition and whether the tube became dislodged during an argument or someone else removed the tube (Tr. 88, 94). Dr. Greenberg could not recall any other case involving a dislodged tracheostomy tube where OCME did not assert jurisdiction (Tr. 95). In Dr. Greenberg's view, this was an obvious OCME case (Tr. 88, 117).

On December 2, 2017, Dr. Greenberg sent an e-mail to respondent's then supervisor, Mr. Cooney, summarizing the extensive efforts by two medical examiners and other staff, further contact with the decedent's family, and a funeral director regarding this case—all because respondent failed to assert OCME jurisdiction (Pet. Ex. 13; Tr. 92). According to the e-mail chain, the disposition of the case was changed from a "no case" to a "certified as an accident" and a new death certificate had to be issued (Pet. Ex. 13; Tr. 108).

Mr. Schultz testified that respondent's report in this case had the standard information in the correct format, but it appeared to be "minimal" (Tr. 28). For example, Mr. Schultz said that it was important to know the name of the reporting physician in a case from a health care facility or the name of the next of kin in a "scene" case (Tr. 29-30, 70). However, Mr. Schultz conceded that he did not know the specifics of this case and that the amount of detail in an investigator's report could "vary greatly" (Tr. 28).

Respondent testified that the reporting physician told him that the decedent had not required a ventilator for a year and the tracheostomy tube was to comfort the parents, there was no functionality associated with it (Tr. 253). The most recent clinical event was bacterial pneumonia, which the treating physician was comfortable certifying as the cause of death, especially because there was no gasping for air or respiratory distress reported and laboratory test results revealed an elevated white count, indicative of an ongoing infection (Tr. 253-54). Respondent claimed that he discussed this case with a tour commander who agreed with his classification of this case (Tr. 254). According to respondent, this was a judgment call where he and the medical examiners disagreed based on the available information (Tr. 255).

At trial, respondent conceded that, upon reflection, his report should have included more details, especially about the dislodged tube (Tr. 314). Respondent said that he did not believe it was clinically relevant because the reporting physician told him that the tube was no longer required (Tr. 315).

This specification should be sustained. Respondent's report refers to the dislodged tube and the unsuccessful efforts by staff to re-insert it. He also noted that EMS later inserted a breathing tube. Dr. Greenberg credibly testified that this was an "obvious" OCME case, especially because it involved the death of a 12-year-old child who EMS transported from his school to an emergency room. Though respondent offered his own theory at trial that the decedent died from an infection, no other witnesses supported this defense. Moreover, by respondent's own admission, his report was deficient because it did not include any of the information that he recalled at trial to the effect that the tube was not medically required and played no part in the decedent's death. As a direct result of respondent's deficient report and failure to exercise jurisdiction over the case, OCME spent considerable time and effort conducting further investigation and had to issue a new death certificate.

At trial, respondent suggested that his failure to include more detail may have been due, in part, to the high volume of cases he had that day (Tr. 315). That claim lacks merit. If respondent believed that the dislodged tube was medically irrelevant, he could have clarified that with a few extra sentences to his report. It would have taken minimal effort for respondent to classify this matter, correctly, as an OCME case.

Case K-18-8479 (Specification F) – not proved

Petitioner alleged that respondent failed to perform an adequate investigation of the death of a 69-year-old man with a history of chronic kidney disease and heart failure, who was found in cardiac arrest after leaving the hospital without permission (ALJ Ex. 1; Pet. Ex. 5). In a report dated April 2, 2018, respondent noted that the patient was hospitalized after presenting in an emergency room with congestive heart failure on March 22, 2018; no ambulance report was available; laboratory tests were negative for alcohol or drug use; and there were no bruising, wounds, or obvious deformities (Pet. Ex. 5). Respondent summarized other test results and the course of treatment, and also noted that there were no other significant clinical events until the patient was seen leaving the hospital on March 26 with a visitor, and he was brought back from an unknown location to the emergency room on March 31, in heart failure (Pet. Ex. 5). The report included the name and phone number of the decedent's next of kin, his mother, and stated that multiple attempts to contact her were unsuccessful (Pet. Ex. 5). According to petitioner, respondent's report was deficient because it lacked basic, necessary information, including the

decedent's drug or alcohol history, the time of death, resuscitative attempts, or the reporting physician's contact information (ALJ Ex. 1).

Dr. Pasquale-Styles testified that respondent "documented very nicely" the emergency room and clinical course of treatment (Tr. 130). However, she recalled spending more than an hour tracking down the reporting physician because respondent included the general hospital number instead of the doctor's direct line (Tr. 130-31). Dr. Pasquale-Styles's main problem with this case was that it did not clearly state the time of death (Tr. 136). The patient returned to the hospital on March 31, but respondent's report was dated April 2 (Pet. Ex. 5).

In an e-mail to respondent on April 3, Dr. Pasquale-Styles noted that OCME staff spent "a fair amount" of time trying to follow up and find out what if any medical treatment the patient received from March 31 to April 2 (Pet. Ex. 16). However, she began the e-mail by telling respondent, "Most of this was not your fault at all" and that the time and date of death were incorrectly entered in petitioner's case management system (Pet. Ex. 16).

Dr. Pasquale-Styles also noted that when she eventually spoke to the reporting physician, she learned that the decedent had a history of cocaine and alcohol abuse (Pet. Ex. 16; Tr. 129-30). In her e-mail to respondent, Dr. Pasquale-Styles reminded him that it was always helpful to ask and document specifically about drug or alcohol history and resuscitation attempts, and to specify the time of death (Pet. Ex. 16). At trial, Dr. Pasquale-Styles again conceded that confusion about the time of death was not respondent's fault (Tr. 135).

Respondent testified that the reporting physician's name and contact number were in the case file (Tr. 272). Thus, he found it redundant to include that information in his investigative report (Tr. 272). However, based on Dr. Pasquale-Styles's feedback, respondent would make every effort to include such details in subsequent reports (Tr. 273-74). Respondent also testified that he normally asked a decedent's next of kin about the decedent's past drug use (Tr. 301).

This charge should be dismissed. Though respondent's report could have included more detail, petitioner failed to show that it was so deficient that it should be deemed negligently, inefficiently, or carelessly prepared. As Dr. Pasquale-Styles conceded, it would be helpful to have the reporting physician's phone number, but it was not something that all investigators included in their reports (Tr. 131). Similarly, Dr. Pasquale-Styles acknowledged that her initial confusion about the date of death was due to a data entry error and not respondent's fault (Tr. 135). Ideally, respondent could have asked the reporting physician about the decedent's history

of drug or alcohol use. But respondent's report noted that the decedent tested negative for current drug or alcohol use and respondent and his co-workers credibly testified that they normally obtained information about past drug or alcohol use from the decedent's next of kin. Here, despite repeated attempts, the decedent's next of kin did not respond to respondent's phone calls.

Case K-18-13266 (Specification E) – sustained

Petitioner alleged that respondent failed to perform an adequate investigation of the death of a 48-year-old man in May 2018 (ALJ Ex. 1). In a report dated May 31, 2018, respondent classified the matter as an OCME case and noted that EMS transported a patient with a history of liver cirrhosis to an emergency room, after the patient complained of abdominal pain and his family called 911 (Pet. Ex. 4). The report, which included the reporting physician's name and telephone number, stated that the ambulance report was unavailable and the reporting physician did not have access to emergency room records. At the beginning of the report, respondent noted that the decedent died in the emergency room. Later in the report, respondent noted that the decedent went into cardiac arrest two hours after arriving in the emergency room and again went into cardiac arrest ten hours later, "presumably due to sepsis of unknown etiology" (Pet. Ex. 4). Petitioner alleged that respondent's report was deficient because it did not explain why the report was dated seven days from the decedent's death (ALJ Ex. 1).

In an e-mail to respondent on June 1, 2018, Dr. Pasquale-Styles stated that it was not clear why this was an OCME case because the decedent was hospitalized for a week and death appeared to be due to complications from acute and chronic alcoholism (Pet. Ex. 15). In a follow-up e-mail to respondent on June 4, Dr. Pasquale-Styles noted that, after receiving some blood test results, she saw that the patient died on May 24 (Pet. Ex. 15; Tr. 125). She noted that it was not clear why respondent's report was dated a week later (Pet. Ex. 15). According to Dr. Pasquale-Styles, all of the medical examiners in the daily triage meeting read the report twice and misinterpreted the clinical treatment as occurring over the course of the week. Though Dr. Pasquale-Styles accepted responsibility for not noticing the date of death as May 24, she told respondent that the circumstances could have been communicated more clearly (Pet. Ex. 15).

At trial, Dr. Pasquale-Styles testified that the report was problematic because it did not explain the delay between the date of death and the date of the report (Tr. 139). Though

respondent noted in the report that the decedent expired in the emergency room, Dr. Pasquale-Styles testified that patients can be treated in emergency room for days (Tr. 139-40). Dr. Pasquale-Styles testified that, by the time she received respondent's report, it was no longer feasible to perform an autopsy (Tr. 126). She ultimately agreed that the decedent died from complications due to alcoholism, but it would have been preferable to perform an autopsy to rule out injury (Tr. 126).

Respondent did not know why there was a week-long delay from the decedent's death until the case was assigned to him (Tr. 264). There was either a delay in reporting the case to OCME or a delay in assigning the case to him, but that he promptly prepared his report (Tr. 265). According to respondent, he considered Dr. Pasquale-Styles's acceptance of responsibility in her e-mail as her acknowledgement that she did not review all of the documents in the case file (Tr. 267). Respondent insisted that the other documents in the case file clearly stated when the decedent died and when the case was reported to OCME (Tr. 267).

This specification should be sustained. In her April 3 e-mail, related to the previous specification, Dr. Pasquale-Styles specifically instructed respondent about the importance of clarifying the date of death. Despite that instruction, respondent's May 31 report again failed to make clear a basic fact—the day the patient died. By repeating the same material error, respondent was negligent and careless.

Though Dr. Pasquale-Styles accepted responsibility for failing to notice that the patient died on May 24, she correctly observed that respondent's report did not clearly specify the date of death. Respondent suggested that he bore no responsibility because there was a delay in assigning the case to him and the correct date of death was listed elsewhere in petitioner's records. Those arguments are mistaken. The purpose of the investigative report is to provide medical examiners with essential details. Medical examiners should not have to hunt elsewhere for basic information, such as the date of death, especially where respondent was explicitly reminded to make that detail clear in his reports.

Case M-18-016646 (Specification G) – not proved

Petitioner alleged that respondent performed an inadequate investigation of the death of 59-year-old man in July 2018 (ALJ Ex. 1). In a report issued July 12, 2018, respondent classified the matter as an OCME case and noted that EMS transported the decedent to an

emergency room on June 29, 2018, after he apparently choked during lunch and became non-responsive. Respondent further noted the ambulance report was unavailable and, based on a telephone interview with the reporting physician, there were no foreign bodies in the decedent's airway, and no bruising, wounds, or obvious deformities (Pet. Ex. 8). The decedent had a history of narcotics and amphetamine use, and a toxicology report indicated the presence of amphetamines (Pet. Ex. 8). Respondent's report also included phone numbers for the decedent's wife and daughter, whom he repeatedly attempted to call, without success (Pet. Ex. 8). Petitioner claimed that respondent's report was deficient because it lacked necessary and basic information, such as the underlying cause of the choking hazard, how and where the choking incident occurred, and the identity of potential witnesses, who reported the choking incident, or a complete phone number for the decedent's daughter (ALJ Ex. 1).

In an e-mail sent to respondent's supervisor, Mr. Schultz, on July 13, Dr. Slone noted that medical examiners had difficulty with this case because they needed more information about the choking incident, including where it occurred and who witnessed it. Dr. Slone also stated that an initial clinical summary worksheet, prepared by the hospital and obtained by respondent, indicated that the decedent was at work and eating lunch when he choked, he coughed up food, and was able to speak briefly before he collapsed (Tr. 165, 179; Pet. Ex. 19). According to Dr. Slone, this was important information that respondent should have noted (Pet. Ex. 19).

At trial, Dr. Slone testified that respondent's report omitted a key detail—whether the decedent's amphetamine use was the result of a prescription medication or drug abuse (Tr. 162). She also faulted respondent for omitting "pertinent negative" information about the choking incident (Tr. 162). As Dr. Slone explained, "You don't choke for no reason" and "99% of the time there is some underlying cause" (Tr. 162-63). Among the basic questions to be asked in a choking case are whether the decedent had been drinking, talking, or eating (Tr. 163-65).

Respondent testified that, as stated in his report, there was no available information regarding the cause of the choking because the ambulance report was not provided, the reporting physician stated that there were no foreign bodies obstructing the airway, and the decedent's spouse was not responding to phone calls (Tr. 282). Though a secondary phone number, for the decedent's daughter, was incorrect, respondent stressed that the decedent's spouse had priority and investigators were not required to list all next of kin (Tr. 284).

Mr. Cooney, a former deputy director of respondent's unit, and Ms. DeVito, an

experienced tour commander, both confirmed that it was standard procedure for investigators to contact family members to obtain more information about the decedent's medical history, similar incidents, and history of alcohol, drug, or tobacco use (Cooney: Tr. 201-03; DeVito: Tr. 353-54). Because family members are occasional difficult to get a hold of, information is not always available by the end of an investigator's shift and another investigator will follow up during the next shift (Cooney: Tr. 201, 230; DeVito: Tr. 349, 351).

This specification should be dismissed. Petitioner faulted respondent for failing to obtain "pertinent negative" information and Dr. Slone identified numerous questions that should be asked in a choking case. Unlike specification A, where respondent spoke to the decedent's mother and neglected to document that he asked relevant questions, here petitioner failed to show how respondent was supposed to obtain missing information by the end of his shift, given the unavailability of the ambulance report, the absence of cooperation from the decedent's wife, and the reporting physician's statement that no foreign bodies or obstructions were identified. Except for the fact that the decedent was at work when the choking occurred and that he spoke briefly after choking up food, which respondent should have included in his report, petitioner failed to demonstrate that respondent could have obtained additional relevant information from the reporting physician or elsewhere. There was, for example, no evidence that a contact number for the decedent's workplace was available or that investigators routinely call a decedent's workplace for more information.

Charge II - Incivility and discourtesy

Petitioner alleged that respondent spoke with the daughter of a decedent on February 22, 2018, and did not offer his condolences, cut her off repeatedly when asking questions, and hung up before she could ask additional questions regarding her father's autopsy. The decedent's daughter also told respondent's supervisor, Mr. Schultz, that respondent gave the impression that he had been inconvenienced by her father's death and he showed no empathy (ALJ Ex. 1).

At trial, petitioner relied on Mr. Schultz's testimony and his report about the incident (Tr. 64; Pet. Ex. 9). He recalled that the complaint was referred to him on February 23, 2018, and he phoned the decedent's daughter (Tr. 64). More than two weeks later, Mr. Schultz summarized that conversation in a memorandum (Tr. 35, 64; Pet. Ex. 9). According to Mr. Schultz, the decedent's daughter stated that she was the human resources director at another agency and she

felt that respondent was very unprofessional and it was important for Mr. Schultz to know how OCME employees were interacting with family members (Tr. 36). In her view, respondent was unprofessional and did not provide information that she wanted (Tr. 36). She claimed that respondent called her to discuss OCME's role following her father's death, he did not offer condolences, cut her off when she asked questions, and ended the conversation by saying, "Good luck to you," and hanging up before she could ask more questions (Pet. Ex. 9).

Mr. Schultz received complaints from family members regarding investigators, but he was not aware of any similar complaints against respondent (Tr. 36, 71). He did not ask respondent for his side of the story because other charges were pending against him (Tr. 64).

Respondent testified that, when he spoke to the decedent's daughter, she appeared to be in the throes of extreme grief, angry, yelling at the top of her voice, and possibly intoxicated (Tr. 286). His standard procedure is to call the next of kin, identify himself, identify the agency, explain why he is calling, explain that strangers are coming to pick up their deceased loved one (Tr. 286). He tries to empathize when discussing the circumstances of death (Tr. 287). He had no recollection of being rude or cutting off the decedent's daughter but he routinely wishes good luck to family members (Tr. 287-88).

Petitioner relied solely on hearsay to prove this charge. Hearsay is admissible at this tribunal and may be sufficient to prove a charge. *See Gray v. Adduci*, 73 N.Y.2d 741, 742 (1988); *Ayala v. Ward*, 170 A.D.2d 235 (1st Dep't 1991). However, hearsay must be reliable and carefully evaluated. *See Health & Hospitals Corp. (Kings Co. Hospital Ctr.) v. Hutchinson*, OATH Index No. 1937/12 at 5-6 (Sept. 28, 2012). Relevant considerations when evaluating hearsay include the declarant's identity, availability, personal knowledge, and independence or bias. *Dep't of Environmental Protection v. Barnwell*, OATH Index No. 177/07 at 7-8 (Sept. 18, 2006). It is also important to consider the level of detail, the amount of corroboration, the centrality of the hearsay to the proponent's case, and the burden upon the proponent if the hearsay was excluded. *Id.*

Here, the decedent's daughter was a concerned civil servant at another agency and had no apparent motive to lie. But she was also a grieving family member. She may not have recalled precisely how respondent began their conversation. There were no contemporaneous notes confirming exactly what she told Mr. Schultz, who waited more than two weeks to write a memorandum about the incident. Besides the claims that respondent failed to express his

condolences and ended the call by wishing the decedent's family "good luck," Mr. Schultz's report lacked specific details and, instead, include subjective conclusions that respondent was rude and he cut the decedent's daughter off before she could ask questions. There were, for example, no details regarding the length of the conversation, what exactly respondent supposedly said at the outset of the conversation, what questions he asked, or what questions he prevented the decedent's daughter from asking.

I was not entirely persuaded by respondent's version of events, which was uncorroborated and self-serving, but that did not relieve petitioner of its burden of proving the charge. Moreover, based on the testimony of respondent's co-workers and respondent's demeanor while testifying, it seemed that he routinely speaks in a polite, respectful tone. The evidence also established that respondent investigates hundreds of deaths per year. He has the extraordinarily difficult task of balancing the need to be respectful when speaking to a grieving family member while simultaneously asking difficult questions about a loved one's drug or alcohol use and medical history. He has performed this task for more than 20 years and his supervisor was unaware of any similar complaint from a family member. Though it is possible that respondent may have forgotten to express his condolences or may have sounded rude on a particular call, petitioner did not prove that occurred here.

Because petitioner failed to meet its burden of proving that respondent was uncivil or discourteous when he spoke to a decedent's family member, this charge should be dismissed.

Additional Rule Violations

Besides charging respondent with inefficient, negligent, or careless performance of duties and incivility or discourtesy, petitioner charged respondent with conduct tending to bring the agency or City into disrepute (Charge I) and conduct prejudicial to good order and discipline (Charge II). These rule violations rely on the identical facts addressed above and should be sustained to the extent that related specifications were sustained, but will not be considered for the penalty recommendation. *See Human Resources Admin. v. Finley,* OATH Index No. 947/05 at 6 (Oct. 12, 2005), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 06-53-SA (Apr. 24, 2006) (sustaining duplicative allegations, including charge that proven misconduct was prejudicial to good order and detrimental to the agency, but declining to make additional penalty findings).

FINDINGS AND CONCLUSIONS

1. Petitioner proved that respondent negligently, inefficiently, or carelessly performed his duties as alleged in Charge I, specifications A, B, D, E.

2. Petitioner failed to prove that respondent negligently, inefficiently, or carelessly performed his duties as alleged in Charge I, specifications C, F, G.

3. Petitioner failed to prove that respondent was uncivil or discourteous as alleged in Charge II.

4. The remaining alleged rule violations are duplicative.

RECOMMENDATION

After making the above findings and conclusions, I requested and received a summary of respondent's personnel record. Petitioner hired respondent in 1995 as a medicolegal investigator I and later promoted him to a medicolegal investigator II.

In his 23-year career with petitioner, respondent has received two warning letters and two suspensions. In 2015, he received a written warning after allegedly leaving a scene before sealing a body bag and mislabeling two cases. In 2010, he received an unsatisfactory work performance memorandum after two incidents where he allegedly failed to remove and voucher personal property from the bodies of decedents. In the first incident, he failed to find a syringe found in a decedent's pocket. In the second incident, the decedent's body arrived at OCME's offices with weapons on his person, after respondent failed to find those items during his examination of the body at the scene. Respondent submitted a written rebuttal in which he asserted that the police were responsible for the search and removal of personal property, and that the property at issue was not medically relevant because both decedents died of natural causes.

In 2007, respondent accepted a penalty of three days' suspension and the loss of 40 days' annual leave in satisfaction of charges that he was accompanied by his teenage son, who was wearing an OCME jacket and carrying a camera and clipboard, when they arrived at the scene of an investigation. In 2003, respondent accepted a penalty of a one-week suspension in satisfaction of charges that, while investigating the site of a Staten Island ferry accident, he removed a piece of ferry equipment without authorization.

More recently, respondent has consistently received positive annual performance evaluations. For each of the past four years he has received overall ratings of "very good." At trial, petitioner tried to discount those evaluations by eliciting from the current deputy director of respondent's unit, Mr. Schultz, that respondent's immediate supervisor, Ms. LaBella, had inflated respondent's ratings and given similar evaluations to other subordinates to compensate for low morale and stressful working conditions among investigators (Tr. 42, 45-46). That argument lacked merit. There were similarities among different employees' performance evaluations, but the evidence also showed that the evaluations were reviewed by others, including department heads, such as Mr. Schultz, who signed off on respondent's most recent "very good" performance evaluation. Though Mr. Schultz wrote beneath his signature that he did not personally oversee respondent's work during the evaluation, the fact remains that Mr. Schultz approved the evaluation and respondent was repeatedly told that he exceeded agency standards. At trial, Ms. LaBella stood by her evaluation of respondent's work (Tr. 341). She explained that if someone scrutinized the hundreds of cases handled by each investigator every year, one would "easily find three cases" that were not the best rated (Tr. 342). Ms. DeVito, another experienced supervisor, confirmed that she was only aware of one instance where there were complaints about respondent's reports (Tr. 347-48).

Petitioner now seeks termination of respondent's employment (Tr. 362). That would be excessive. To begin with, petitioner based its penalty request, in part, on the assumption that it had proved all of the charges. Because petitioner failed to prove some of the charges, a lesser penalty would be appropriate.

In cases involving negligent rather than intentional misconduct, termination of employment is more suitable for those employees who are incapable of meeting relevant standards or endanger public safety. *See, e.g., Health & Hospitals Corp. (Harlem Hospital Ctr.) v. Triana*, OATH Index No. 282/17 at 25-26 (May 30, 3017) (termination of employment recommended where clinical dietician, with 15 years of experience, one prior suspension, and substandard performance evaluations, was "unwilling or unable to meet the basic duties of his job;" "consistently unable to perform his fundamental responsibilities," which included "accurately assessing the nutritional status of patients and providing appropriate dietary recommendations;" and posed a threat to patient safety); *Dep't of Finance v. Kateme*, OATH Index No. 728/17 at 26-27 (Feb. 2, 2017) (termination of employment recommended where tax

auditor, with six years of experience, a prior disciplinary history, and five years of "unsatisfactory" performance ratings, demonstrated a pattern of incompetence and unwillingness to perform her job).

In contrast, lesser penalties are warranted for isolated acts of misconduct. *See, e.g.*, *Dep't of Health & Mental Hygiene v. Levia-Mena*, OATH Index No. 851/14 (Mar. 14, 2014), *aff'd*, NYC Civ. Serv. Comm'n Case No. 2014-0614 (Mar. 27, 2015) (12-day suspension upheld where computer aide, with nine years of experience, no prior disciplinary record, and good performance evaluation, was discourteous and inefficient in performing her duties relating to a home day care provider); *see also Hines*, OATH 073/17 at 23 (30-day suspension imposed where long-term employee, with three prior disciplinary charges, was loud and disrespectful, refused to attend a meeting, and did not process client applications in a timely manner over the course of three months, which caused significant grief to clients); *Dep't of Environmental Protection v. Golden*, OATH Index No. 1519/13 (Sept. 9, 2013), *modified*, Comm'r Dec. (Nov. 27, 2013) (30-day suspension imposed where laboratory associate, with 20 years' experience, three prior disciplinary penalties, and favorable recent performance evaluations, committed multiple acts of misconduct, including insubordination, discourtesy, and repeated negligent failure to perform tasks); *Transit Auth. v. Victor*, OATH Index No. 799/11 (Mar. 3, 2011), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 11-52-A (Aug. 9, 2011) (25-day suspension upheld where computer specialist with more than 30 years of experience, no prior proven charges of misconduct, and satisfactory evaluations, made six careless errors over the span of six months, but evidence showed that these were "isolated judgment errors" rather than overall incompetence).

Here, based on the importance of the work to OCME's mission, petitioner rightfully expects investigators to meet high standards of professionalism. The sustained charges went beyond ordinary errors. On multiple occasions respondent submitted deficient reports.

Some of the medical examiners opined that they lacked confidence in respondent's work and expressed doubt about his ability to change (Slone: Tr. 145; Pasquale-Styles: Tr. 214). But those subjective beliefs are not enough to prove that respondent is incapable of performing his job. *See Transit Auth. v. Ondeje*, OATH Index No. 1339/04 at 12 (Dec. 30, 2004) ("Generalized assessments of performance," alone, do not prove incompetence; instead, is necessary to show that employee received notice that work performance was deemed inadequate and that includes memoranda given to employee and performance evaluations). Notably, medical examiners sent

e-mails pointing out deficiencies in respondent's work but those e-mails were not always sent to respondent. At trial, respondent credibly maintained that he was receptive to constructive suggestions. This was corroborated by Ms. LaBella who said that respondent was very responsive to suggestions (Tr. 327).

A substantial penalty is warranted based on the serious nature of respondent's errors and his significant disciplinary history. However, I was not persuaded by petitioner's claim that respondent is incapable of improving or unreceptive to constructive suggestions. Accordingly, I recommend ten days' suspension for each of the proven specifications, for a total penalty of 40 days' suspension without pay.

Kevin F. Casey
Administrative Law Judge

April 5, 2019

SUBMITTED TO:

DR. OXIRIS BARBOT
Commissioner

APPEARANCES:

KARRIE SHERIDAN, ESQ.
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Attorney for Respondent

THE CITY OF NEW YORK
CITY CIVIL SERVICE COMMISSION

In the Matter of the Appeal of

ROBERT YEE
Appellant

-against-

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Respondent

Pursuant to Section 76 of the New York State Civil Service Law

CSC Index No: 2019-0436

DECISION

ROBERT YEE ("Appellant") appealed from a determination of the Department of Health and Mental Hygiene finding Appellant guilty of incompetence and/or misconduct and imposing a penalty of a 40-day suspension following disciplinary proceedings conducted pursuant to Civil Service Law Section 75.

The Civil Service Commission ("Commission") heard arguments from the parties on August 8, 2019.

The Commission has considered the arguments presented on this appeal, and reviewed the record of the disciplinary proceeding. Based on this review, the Commission concludes that there is sufficient evidence in the record to support the findings of fact and the conclusions of law, and that the penalty is appropriate.

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Therefore, the final decision and penalty imposed are hereby affirmed.

SO ORDERED.

Dated: September 5, 2019